

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0009175</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Golden Good Shepherd Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>11/01/02</u> to <u>10/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>101 Prairie Mills Road</u> <u>Golden</u> <u>62339</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Adams</u>		Officer or Administrator of Provider (Signed) <u>1/30/04</u> (Type or Print Name) <u>Sandra Fenn</u> (Date)	
Telephone Number: <u>217-696-4421</u> Fax # <u>217-696-4393</u>		(Title) <u>Administrator</u>	
IDPA ID Number: <u>37-0843671001</u>		(Signed) <u>1/30/04</u> (Date)	
Date of Initial License for Current Owners: <u>12/9/63</u>		Paid Preparer (Print Name and Title) <u>Chad Passley</u> <u>Owner</u>	
Type of Ownership:		(Firm Name & Address) <u>Chad Passley, CPA</u> <u>PO Box 186/107 W 5th St Golden, IL 62339</u>	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Telephone) <u>217-696-4866</u> Fax # <u>217-696-4866</u>	
<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
In the event there are further questions about this report, please contact: Name: <u>Chad Passley</u> Telephone Number: <u>217-696-4866</u>			

STATE OF ILLINOIS

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Facility Name & ID Number Golden Good Shepherd Home# 0009175 Report Period Beginning: 11/01/02 Ending: 10/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>42</u>	Skilled (SNF)	<u>42</u>	<u>15,330</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>42</u>	TOTALS	<u>42</u>	<u>15,330</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>630</u>	<u>729</u>		<u>1,359</u>	8
9	SNF/PED					9
10	ICF	<u>3,754</u>	<u>8,373</u>		<u>12,127</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>4,384</u>	<u>9,102</u>		<u>13,486</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 87.97%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒NO ☐

I. On what date did you start providing long term care at this location?

Date started 12/9/63

J. Was the facility purchased or leased after January 1, 1978?

YES ☐

Date _____

NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒

If YES, enter number

of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☐ NO ☐Tax Year: 10/31/03 Fiscal Year: 10/31/03

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning: 11/01/02

Ending: 10/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	97,940	7,074	4,316	109,330		109,330		109,330			1
2	Food Purchase		65,308		65,308	(12,000)	53,308	(2,510)	50,798			2
3	Housekeeping	36,892	7,738		44,630		44,630		44,630			3
4	Laundry	23,813	27,402		51,215		51,215		51,215			4
5	Heat and Other Utilities			45,127	45,127		45,127	(2,878)	42,249			5
6	Maintenance	28,116	10,499	7,010	45,625		45,625	(394)	45,231			6
7	Other (specify):*			14,237	14,237		14,237		14,237			7
8	TOTAL General Services	186,761	118,021	70,690	375,472	(12,000)	363,472	(5,782)	357,690			8
	B. Health Care and Programs											
9	Medical Director			1,500	1,500		1,500		1,500			9
10	Nursing and Medical Records	561,959	46,254	2,877	611,090		611,090		611,090			10
10a	Therapy	42,116		2,686	44,802		44,802		44,802			10a
11	Activities	32,536	1,957	1,946	36,439		36,439		36,439			11
12	Social Services	21,497		1,946	23,443		23,443		23,443			12
13	Nurse Aide Training											13
14	Program Transportation			1,200	1,200		1,200		1,200			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	658,108	48,211	12,155	718,474		718,474		718,474			16
	C. General Administration											
17	Administrative	42,117		4,509	46,626		46,626	(2,500)	44,126			17
18	Directors Fees											18
19	Professional Services			1,871	1,871		1,871		1,871			19
20	Dues, Fees, Subscriptions & Promotions			299	299		299		299			20
21	Clerical & General Office Expenses	29,093	8,858	3,906	41,857		41,857	(2,000)	39,857			21
22	Employee Benefits & Payroll Taxes			129,865	129,865	12,000	141,865		141,865			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,545	2,545		2,545		2,545			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			72,564	72,564		72,564	(8,000)	64,564			26
27	Other (specify):*											27
28	TOTAL General Administration	71,210	8,858	215,559	295,627	12,000	307,627	(12,500)	295,127			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	916,079	175,090	298,404	1,389,573		1,389,573	(18,282)	1,371,291			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number

Golden Good Shepherd Home

#0009175

Report Period Beginning:

11/01/02

Ending:

10/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			48,315	48,315		48,315	(11,068)	37,247			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			7,491	7,491		7,491	(7,491)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			55,806	55,806		55,806	(18,559)	37,247			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			22,995	22,995		22,995		22,995			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			22,995	22,995		22,995		22,995			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	916,079	175,090	377,205	1,468,374		1,468,374	(36,841)	1,431,533			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/02

Ending:

10/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	2,510	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	34,331	21,26,30,33		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 36,841		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 36,841		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Golden Good Shepherd Home

ID# 0009175

Report Period Beginning: 11/01/02

Ending: 10/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

10/31/03

10/31/03

[illegible]

Summary B

10/31/03

10/31/03

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/02 Ending: 10/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	None								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/02 Ending: 10/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	N/A						\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
10	N/A											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$

Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Golden Good Shepherd Home**# **0009175** Report Period Beginning: **11/01/02** Ending: **10/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2002 report.			\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	7,491 2
3. Under or (over) accrual (line 2 minus line 1).			\$	7,491 3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7,491 7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1998	6,613	8	
	1999	6,512	9	
	2000	6,654	10	
	2001	7,178	11	
	2002	7,491	12	
				FOR OHF USE ONLY
				13 FROM R. E. TAX STATEMENT FOR 2002 \$ 13
				14 PLUS APPEAL COST FROM LINE 5 \$ 14
				15 LESS REFUND FROM LINE 6 \$ 15
				16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Golden Good Shepherd Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0009175

CONTACT PERSON REGARDING THIS REPORT Chad Passley

TELEPHONE 217-696-4866 FAX #: 217-696-4866

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>02-0-0647-000-00</u>	<u>Lot 17 Block 10</u>	\$ <u>7,222.00</u>	\$ _____
2. <u>02-0-0649-000-00</u>	<u>Lot 3 Block 11</u>	\$ <u>269.00</u>	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>7,491.00</u></u>	\$ <u><u> </u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A. Square Feet:

18,748

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

One

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Schedule Attached	475,705		\$ 37,727	1
2					2
3	TOTALS	475,705		\$ 37,727	3

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/02

Ending:

10/31/03

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	42		1963	1963	\$ 163,629	\$ 3,273	50	\$ 3,273		\$ 130,903	4
5			1988	1988	208,384	5,210	40	5,210		79,012	5
6			1989	1989	84,694	2,117	40	2,117		30,878	6
7											7
8											8
		Improvement Type**									
9		Building Addition		1967	5,285		20			5,285	9
10		Building Addition		1973	25,841		20			25,841	10
11		Sprinkler System		1975	30,963		20			30,963	11
12		Central Air Conditioning		1975	18,103		10			18,103	12
13		Building Addition		1975	1,313		20			1,313	13
14		Building Addition		1976	15,380		20			15,380	14
15		Building Addition		1977	3,981		15			3,981	15
16		Building Doors		1978	900		20			900	16
17		Building Addition		1980	3,165		15			3,165	17
18		Blacktop Parking Lot		1985	7,475		15			7,475	18
19		Building Addition		1983	4,174		15			4,174	19
20		Garage		1986	6,473		15			6,473	20
21		Landscaping		1988	620		10			620	21
22		Asphalt Parking Lot		1989	950	63	15	63		950	22
23		Building Addition		1990	655	33	20	33		428	23
24		Sprinkler System Upgrade		1992	43,248	1,730	25	1,730		19,750	24
25		Floor & Foundation Improvements		1997	9,800	251	39	251		1,738	25
26		Parking Lot Expansion		1997	16,320	418	39	418		2,650	26
27		Oxygen Room Venting		1998	2,880	72	40	72		408	27
28		Backflow Valve		1998	959	38	25	38		195	28
29		Laundry Door		1998	3,555	237	15	237		1,185	29
30		Backflow Preventor		1999	3,128	156	20	156		717	30
31		Install Ceiling		1999	4,657	233	20	233		951	31
32		Kitchen Floor		2000	1,167	117	10	117		438	32
33		New Roof Nursing Home		2001	38,956	999	39	999		2,164	33
34		Concrete - Activity Room Entrance		2003	4,975	166	15	166		166	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 711,630	\$ 15,113		\$ 15,113	\$	\$ 396,206	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 426,596	\$ 22,074	\$ 22,074	\$		\$ 308,183	71
72	Current Year Purchases	2,170	60	60			60	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 428,766	\$ 22,134	\$ 22,134	\$		\$ 308,243	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,178,123	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 37,247	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 37,247	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 704,449	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Schedule Attached	\$ 455,396	\$ 11,068	\$ 204,963	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 455,396	\$ 11,068	\$ 204,963	91

G. Construction-in-Progress

	Description	Cost	
92	None	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$

13. /2005 \$

14. /2006 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	N/A	hrs	\$		\$
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 103,329	\$	1
2	Cash-Patient Deposits	256		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	41,287		3
4	Supply Inventory (priced at)	4,000		4
5	Short-Term Investments	138,752		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 287,624	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	218,479		12
13	Land	40,555		13
14	Buildings, at Historical Cost	1,147,111		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	445,853		16
17	Accumulated Depreciation (book methods)	(909,411)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 942,587	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,230,211	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 17,468	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	256		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	19,080		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 36,804	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 36,804	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,193,407	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,230,211	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,322,104	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,322,104	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(143,285)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	30,357	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Adjustment	(15,769)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (128,697)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,193,407	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,257,985	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,257,985	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,510	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	29,746	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	2,427	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 34,683	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,049	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,049	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Management Fee	21,000	28
28a	Other Income	7,372	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 28,372	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,325,089	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	375,472	31
32	Health Care	718,474	32
33	General Administration	295,627	33
	B. Capital Expense		
34	Ownership	55,806	34
	C. Ancillary Expense		
35	Special Cost Centers	22,995	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,468,374	40
41	Income before Income Taxes (line 30 minus line 40)**	(143,285)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (143,285)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

Page 20

Facility Name & ID Number Golden Good Shepherd Home# 0009175Report Period Beginning: 11/01/02Ending: 10/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,136	2,203	\$ 39,480	\$ 17.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses	87	87	1,628	18.71	3
4	Licensed Practical Nurses	10,133	10,968	150,318	13.71	4
5	Nurse Aides & Orderlies	26,338	28,084	294,280	10.48	5
6	Nurse Aide Trainees	2,223	2,463	22,982	9.33	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,757	3,055	42,116	13.79	8
9	Activity Director	1,807	2,127	22,683	10.66	9
10	Activity Assistants	1,659	1,694	9,853	5.82	10
11	Social Service Workers	2,727	2,851	21,497	7.54	11
12	Dietician					12
13	Food Service Supervisor	1,922	2,143	20,008	9.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,981	11,558	77,932	6.74	15
16	Dishwashers					16
17	Maintenance Workers	1,932	2,130	28,116	13.20	17
18	Housekeepers	3,749	3,992	36,892	9.24	18
19	Laundry	2,963	3,134	23,813	7.60	19
20	Administrator	2,060	2,252	42,117	18.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,893	2,121	29,093	13.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,404	1,523	21,272	13.97	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Care Plan Coordin</u>	1,842	2,072	31,999	15.44	33
34	TOTAL (lines 1 - 33)	78,613	84,457	\$ 916,079 *	\$ 10.85	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	125	\$ 4,317	VA1(4)	35
36	Medical Director	12	1,500	VB9(3)	36
37	Medical Records Consultant	19	1,650	VB10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	51	1,227	VB10(3)	39
40	Physical Therapy Consultant	44	2,686	VB10a(3)	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	31	1,946	VB11(3)	44
45	Social Service Consultant	31	1,946	VB12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	313	\$ 15,272		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Nurse Aides	0	0		52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount			
Sandra Fenn	Administrator	0	\$ 37,998	Workers' Compensation Insurance	\$ 30,305	IDPH License Fee	\$			
Julia Smith	Administrator	0	3,069	Unemployment Compensation Insurance	4,720	Advertising: Employee Recruitment				
Cindi Balance	Administrator	0	1,050	FICA Taxes	76,953	Health Care Worker Background Check (Indicate # of checks performed _____)				
				Employee Health Insurance	17,432	Misc Dues, Fees, Subscriptions	299			
				Employee Meals	12,000					
				Illinois Municipal Retirement Fund (IMRF)*						
				Continuing Education	455					

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Golden Good Shepherd Home

STATE OF ILLINOIS

0009175

Report Period Beginning:

11/01/02

Ending:

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10/31/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network 1947
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,516 Line VB10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 22,995
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 12,000 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.